UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

IN RE: PRADAXA (DABIGATRAN ETEXILATE) PRODUCTS LIABILITY LITIGATION	3:12-MD-02385-DRH-SCW MDL No. 2385

PLAINTIFF FACT SHEET

For each case, each Plaintiff must complete this Plaintiff Fact Sheet ("PFS") and identify or provide documents and/or data responsive to the questions set forth below to the best of Plaintiff's knowledge. In completing this PFS, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. The PFS shall be completed in accordance with the requirements and guidelines, including the time limitations, set forth in Case Management Order No. 15. These responses are confidential and subject to the provisions of the Protective Order. See e.g., CMO 2.

In the event the PFS does not provide you with enough space for you to complete your responses or answers, please attach additional sheets if necessary.

This PFS pertains to the following case:

Case caption:_____

Civil Action No._____

Principle Attorney:_____

I. CASE INFORMATION

A. Name(s) of person(s) completing this form and relationship to person who used Pradaxa:

First Name:_____Middle:_____Last:_____Suffix:_

Address:_____City:_____State:_____Zip:_____

Relationship to injured party:_____

II. PERSONAL INFORMATION ABOUT PERSON WHO CLAIMS INJURY FROM INGESTING PRADAXA

A. First Name:_____ Middle:_____ Last:_____ Suffix:_

B. Current Address and Date when you began living at this address:

Address:_____ City:_____ State:_____ Zip:_____

Date you began living at this address:_____

C. Other than your current address, identify each address at which you have resided during the last five (5) years, and the dates you resided at each one:

Address, City, State, Zip	Dates of Residence

D. Social Security Number:_____

E. Date of Birth:_____ Place of Birth:_____

F. Current Marital Status:_____

G. If married, name and occupation of current spouse:

First Name:_____ Middle:_____ Last:_____ Suffix:_

Occupation:_____

H. For any marriages that ended within the past five (5) years, please provide the name of such former spouse(s), the dates(s) of marriage(s) and the dates(s) the marriage(s) ended, and the nature of the termination. (*Ex. Death or Divorce)*

Spouse Name	Begin Date	End Date	Nature of the Termination

I. If you have children, please identify each child's name, state of residence and age.

Child's Name	State of Residence	Age

J. Please state your highest level of education, including the name of the institution you attended and the degree you obtained:

Highest Level of Education	Name of Institution	Degree (If Applicable)

K. For the ten (10) year period prior to the date you first took Pradaxa, please identify each of your employers, the position you held and the dates of employment with each employer.

Name of Employer	Position(s) Held	Dates of Employment

L. Are you making a claim for lost wages or lost earning capacity? Yes☐No☐ *If "Yes",*

(1) Please provide the address for each employer identified above and state the following for the last five (5) years:

Name of Employer	Employer Address, City, ST, Zip	Year	Annual Gross Income

M. If you left any employment for medical reason within the seven (7) year period before you began taking Pradaxa please describe why you left such employment:_____

_____

_____

N. Have you ever served in any branch of the military? *"Yes",*

Branch:_____Dates of Service:_____

Were you ever discharged or rejected from any type of military service for any reason relating to your medical or physical condition? *"Yes", please state the condition:*

Condition:_____

O. Identify each insurance carrier with whom you had health insurance coverage at any time beginning five (5) years prior to using Pradaxa up to the present, and please include all private insurance and public assistance if applicable:

Name of Insurance Company Or Public Assistance (if known)	Name of Policy Holder/Insured (If different than you)	Approx. Dates of Coverage

P. Have you applied for worker's compensation, social security disability benefits, private disability benefits, or state or federal disability benefits within the ten (10) year period prior to the date of your completion of this fact sheet?

"Yes", then as to each application, separately state:

1. Name of agency:_____Date of application:_____

2. Nature of claimed injury/disability:_____

Q. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past ten (10) year?

"Yes", please complete the following:

Nature of the case:_____

Where was it filed?_____

Attorney name:_____

R. In the past ten (10) years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an act of dishonesty or providing a false statement? Yes☐No☐

If "Yes", please complete the following:

Charge to which you plead guilty or were convicted of:_____

Court where action was pending:_____

III. HEALTH CARE PROVIDERS AND PHARMACIES *(Please attach extra pages as necessary to fully answer this section.)*

A. Identify each doctor or other health care provider who you have seen for medical care and treatment within seven (7) years prior to your use of Pradaxa. You may exclude from this answer those doctors or health care providers who did not provide treatment for (a) the injuries associated with those claimed in your case or (b) who did not provide any treatment related to any condition(s) that resulted in your use of any anticoagulant medication, including warfarin or Pradaxa. You may not exclude from this list any cardiologists, gastroenterologists, neurologists or your general internal medicine/primary care physician.

Doctor or Healthcare Provider's Name	Doctor or Healthcare Providers Specialty	Address, City, ST, Zip	Reason for Visit	Approx. Dates/Years of Visits

B. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, outpatient, or emergency room visit) within seven (7) years prior to your use of Pradaxa.

Name	Address, City, State, Zip	Admission Dates	Reason for Admission

C. Identify each pharmacy that has dispensed Pradaxa, any anticoagulant including warfarin, or any medication related to the treatment or prevention of atrial fibrillation or stroke in the seven (7) year period prior to your completion of this fact sheet:

Name of Pharmacy	Address, City, State and Zip	Name of Medication Dispensed	Approx. Dates/Years you used this pharmacy

IV. MEDICAL BACKGROUND

A. Height and weight at the Time of Your Claimed Injury: Height:_____Weight:_____

B. Tobacco use history: For the ten (10) year period prior to your use of Pradaxa up to the present, check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/snuff.

☐ I have never used tobacco

☐ I used tobacco in ten-year period prior to my use of Pradaxa

C. Types of Tobacco Used: ☐Cigarettes ☐Cigars ☐Pipes ☐Chewing tobacco/snuff

D. Approximate Amount used: on average _____ per day for _____ years

E. I currently use tobacco: Yes☐ No☐

F. Alcohol Consumption: For the ten (10) years prior to your use of Pradaxa up to the present, did you drink alcohol (beer, wine, etc.)?Yes☐No☐

If "Yes", what was your approximate average alcohol consumption during that time?

Drinks per week/monthly/year/other:_____

If other, describe:_____

G. Have you ever had any medical procedure performed in which a stent was used? Yes☐No☐

If yes: Type of stent:_____Approximate Date:_____

H. Have you ever required a blood transfusion? Yes☐No☐

If yes, what was the reason?_____

I. In the ten (10) year period prior to when you first took Pradaxa, were you ever diagnosed with or treated for any of the following conditions? Please selected "Yes", "No" or "Unknown" for each condition. For each condition for which you answered, "Yes", please provide the additional information requested in subpart (1):

Condition	Yes	No	Unknown/not sure
Anemia (or low blood count/low hematocrit)			
Bleeding or clotting disorder			
Internal Blood Clots or Deep Vein Thrombosis (DVT)			
Cancer of any Type (Including lung, colon, liver, breast, kidney, stomach, testicular, leukemia, Hodgkin's disease or Non-Hodgkin's lymphoma)			
Cerebral or brain hemorrhage			
Congestive Heart Failure			
Crohn's Disease			
Diabetes			
Diverticulitis			
Gastrointestinal bleeding			
Heart Attack, MI/Myocardial Infarction			
Hypertension (High Blood Pressure)			

Inflammatory Bowel Disease or Irritable Bowel Syndrome			
Kidney problems (disease, infections, stones, protein in urine, etc.)			
Lupus			
Pulmonary Embolism/blood clot in lung			
Stomach Ulcers/Peptic Ulcers			
Stroke of any type (hemorrhagic, ischemic, etc.)			
Transient ischemic attack (TIA)			
Ulcerative Colitis			
Vascular disease of any type (including vasculitis or peripheral vascular disease			

(1) For each condition for which you answered "Yes" in the previous chart, please provide the information requested below (and attach additional pages as necessary):

Condition	**Treating Health Care Provider or Health Care Facility**	**Address, City, ST, Zip**	**Approx. Date of Onset**

V. ADDITIONAL MEDICATIONS

A. Are there any prescription medications that you have taken on a regular basis in the seven (7) year period before you first took Pradaxa? For purposes of this question, "regular basis" mean that you were directed by a health care provider to take a medication for at least forty-five (45) consecutive days. Yes☐No☐

(1). If "Yes", please provide the following information for each prescription medication:

Name of Prescription Medication Used on a Regular Basis	The health care provider(s) that Prescribed the medication	Approx. Dates/years taken

B. For the twenty (20) day period before the onset of the injuries for which recovery is sought in this action, set forth: (a) the name of each and every over the counter and prescription drug product ingested or otherwise used by you; (b) the prescribing physician, if any; and (c) the pharmacy where the product was purchased.

Name of over-the-counter or prescription drug:	Prescribing health care provider (if any)	Pharmacy where purchased

C. Do you currently take, or have you ever taken in the last ten (10) years, any of the following medications or supplements? (Generic name is followed by brand name):

Name of Medication	Yes	No	Not sure/Unknown	Name of dispensing pharmacy
Warfarin (Coumadin)				
Plavix (Clopidogrel)				
Aggrenox (Aspirin and Extended Release Dipyridamole in Combination)				
Heparin				
Lovenox (Enoxaparin)				
Rivaroxaban (Xarelto)				
Anisindione (Miradon)				
Prasugrel (Effient)				
Aspirin on a regular basis (such as once a day for more than two weeks)				
Non-Steroidal Anti-Inflammatory drugs (NSAIDs) regularly for more than four (4) weeks consecutively (NSAIDs include Ansaid, Pontsel, Toradol, Acular, Feldene, Naprosyn, Lodine				
Dronaderone (Multaq)				
Mannitol				
Cimetidine (Tagamet)				
Amiodarone (Cordarone, Pacerone)				
Quinidine				

VI. FAMILY HISTORY

A. Please indicate, to the best of your knowledge, whether your parents, sibling or grandparents have ever suffered from any of the following:

Condition	Yes	No	I do not Know Unsure/Unknown
Bleeding/Clotting disorders (hemophilia, Von Willebrand's disease, others)			
Blood Clots			
Blood Disorders			
Cerebral Hemorrhages			
Cerebral Aneurysm, Vascular Malformation or Amyloid Angiopathy			
Deep vein thrombosis/DVT/Blood Clots in lower legs			
Hemorrhages (intestinal, vaginal, etc.)			
Liver Disease (hepatitis B/C, cirrhosis, cysts, abnormal enzymes, etc.)			
Strokes of any type (e.g., ischemic stroke, hemorrhagic stroke)			

(1) For each condition for which you answered "Yes" in the immediately preceding chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Date of Onset (approx.)	Family Member's Relationship to you	Treatment and Outcome (If known)

VII. PRADAXA USE

A. Dates of use: _____

(1) Provide in the chart below the name(s) and address(es) of the health care provider(s) who prescribed or provided the Pradaxa:

Name of health care provider(s)	Address, City, State and Zip

(2) Provide below the name(s) and address(es) of the pharmacy(ies) or other store(s) or location(s) from which you obtained Pradaxa:

Name of Pharmacy or other Store/Location	Address, City, State and Zip

B. Did you receive any samples of Pradaxa? Yes☐No☐ I do not recall☐

If "Yes", Who Provided?_____When?_____

C. Did you receive a Medication Guide with your prescription of Pradaxa? Yes☐No☐ I do not recall☐

D. Do you have in your possession or does your attorney have the packaging, the Medication Guide or any information you received from your healthcare provider or pharmacist from/about the Pradaxa you alleged to have used?

Yes☐No☐ If "Yes", what information do you or your attorney have and how has custody of it?_____

_____

E. Have you ever seen any advertisements (e.g., in magazines or television commercials) for Pradaxa?

Yes☐No☐

If "Yes", please identify where you saw the advertisement(s) and the approximate date you saw the advertisement(s)

_____

If in a magazine(s), do you or your attorney have a copy of the advertisement(s) Yes☐No☐

Specify who has custody of it: _____

F. Other than through your attorneys, have you had any communication, oral or written, with any of the Defendants or their representatives to/from you and any of the Defendants?

Yes☐No☐ I do not recall☐ *If "Yes", please provide the following information:*

Date of communication:_____Method of communication:_____

Name of Representative:_____

Substance of the communication between you and any representatives of the Defendants:_____

_____

_____

VIII. INJURIES & DAMAGES

A. Please identify your injury(ies) by checking the appropriate box(es) below. If your injury is not listed, choose "Other" and specify your injury accordingly:

Yes	Injury
	Stroke (Hemorrhagic) Brain/Cerebral Hemorrhage
	Gastrointestinal Bleeding
	Heart Attack secondary to bleeding
	Unspecified Internal Bleeding
	Kidney Bleeding
	Nosebleeds
	Rectal Bleeding
	Respiratory Failure
	Stroke (Ischemic)
	Vaginal Bleeding
	Other *

* If you checked other, identify all injuries that you are claiming that are not listed in the above chart.

B. (1) If you were taken to a doctor or health care facility (e.g., hospital or clinic) to be treated for the injury(ies), state the name and address (if known) of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility:

Name	Address, City, State and Zip

(2) Were you treated by any health care provider or at any hospital for this/these injury(ies)? Yes☐ No☐

If "Yes", please provide the following information:

Name of health care provider and Hospital	Address, City, State and Zip	Approx. date(s) of treatment

C. Do you claim that your use of Pradaxa caused or aggravated any psychiatric and/or psychological condition(s) for which treatment was sought and for which damages are being sought in this lawsuit? Yes☐ No☐

(1) If "Yes", please state the following as it pertains to your treatment of any psychiatric and/or psychological condition(s) in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address, City, State, Zip, Telephone Number	Reason for Treatment	Approx. Dates/Years of Treatment/Visits

D. Have you had any communications with your health care providers, orally or in writing about whether your condition is related to your use of Pradaxa? Yes☐ No☐ I do not recall☐

If "yes" please provide the following information:

Name of health care provider:_____

Address:_____ City:_____ State:_____ Zip:_____

Approximate date of communication:_____

E. Are you claiming out of pocket expenses as a result of your Pradaxa use? *"Yes"*,

Amount or approx. amount:_____ Category/types of expenses:_____

_____

IX. FACT WITNESSES

A. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your health care providers, and please state their name, address and his/her relationship to you (attach additional pages as necessary):

Name	Address, City, State, Zip	Relationship to you

B. If there are any individuals who witnessed your injury as it occurred, other than healthcare providers, and who are not listed in the chart directly above, please identify them here by name, address and their relationship to you.

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Relationship to you:_____

X. **DECLARATION**

Pursuant to 28 U.S.C § 1746, I declare under oath and do hereby swear and affirm that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

_____

Signature of Plaintiff

_____

Date

XI. DOCUMENT DEMANDS

A. AUTHORIZATIONS

1. Health care Authorizations - For each health care provider identified in the PFS, please provide a completed and signed (but undated) Authorization in the form attached as Exhibit "A."

2. Tax Return 4506 and 4506-T IRS Forms -

   a) Only if you answered "Yes" to question II.L in the PFS and are asserting a claim for lost wages or a reduction in lost earning capacity, please provide W-2 or 1099 forms for the past five years. If you are unable to provide W-2 or 1099 forms you must provide a completed and signed IRS Form 4506 and 4506-T attached as Exhibit "B" for each year identified in your answer to question II.L.

   b) If you answered "No" to question II.L in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide W-2s, 1099s, or a completed and signed IRS Form 4506 and 4506-T.

3. Authorizations for the Release of Employment Records - If you are asserting a claim for lost wages or a reduction in or lost earning capacity please provide a completed and signed (but undated) Authorization in the form attached as Exhibit "A" for each employer identified in paragraph II.K in the PFS.

4. Authorization for Release of Workers' Compensation Records - If you answered "Yes" to question II.P in the PFS, stating that you applied for workers' compensation within the past ten (10) years, please provide a completed and signed (but undated) Authorization in the form attached as Exhibit "A".

5. Authorization for Release of Disability Records - If you answered "Yes" to question II.P in the PFS, stating that you applied for disability within the past ten (10) years, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the last 10 years in the form attached as Exhibit "C".

6. Insurance Records Authorization- For each company listed in your response to question II.O in the PFS, please provide a completed and signed (but undated) Authorization in the form attached as Exhibit "A".

B. OTHER RELEVANT DOCUMENTS

Documents[1] in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this PFS):

1. A copy of all medical records and/or documents relating to the use of Pradaxa from any hospital or health care provider who treated you in the past 10 years and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Pradaxa including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in your Complaint. Yes☐No☐

2. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding. Yes☐No☐

3. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Pradaxa. Yes☐No☐

4. Copies of advertisements or promotions for Pradaxa and articles discussing Pradaxa. Yes☐No☐

5. Copies of the entire packaging, including the box and label for Pradaxa (plaintiffs or their counsel must maintain the originals of the items requested in this subpart). Yes☐No☐

6. All documents relating to your purchase of Pradaxa including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase. Yes☐No☐

7. All documents known to you and in your possession which mention Pradaxa or any alleged health risks or hazards related to Pradaxa in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney or documents obtained or created for the purpose of seeking legal advice or assistance. Yes☐No☐

8. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants. Yes☐No☐

9. All documents constituting any communications or correspondence between you and any representative of the Defendants. Yes☐No☐

10. All photographs, drawing, journals, slides, videos, DVDs or any other media, including any "day in the life" videos, photographs, recordings or other media that you may utilize to demonstrate damages or relating to your alleged injury. Yes☐No☐

11. Copies of all documents you (and not your lawyer) obtained from any source related to Pradaxa or to the alleged effects of using Pradaxa. Yes☐No☐

12. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers. Yes☐No☐

13. Copies of any writings comprising or relating to any public statements made by you relating to this litigation in your possession. Yes☐No☐

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[1] "Document" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

14. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes ☐ No ☐

15. Decedent's death certificate and autopsy report (if applicable). Yes ☐ No ☐

Exhibit A

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:

Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: MRC, 10114 West Sam Houston Parkway South, Suite 200, Houston, TX 77099, copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* The undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.
* All employment or insurance records
* All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____(plaintiff/representative)
Signature: _____ _____ (Dated)

Exhibit B1

Form **4506**

(Rev. January 2012)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b** **First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b** **Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your IRS return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____	_____	_____	_____
_____	_____	_____	_____

8 **Fee.** There is a $57 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ **$57.00**
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . ☐

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here	▶ **Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
	▶ **Spouse's** signature	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

What's New

The IRS has created a page on IRS.gov for information about Form 4506 and its instructions, at *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506, Form 4506T and Form 4506T-EZ will be posted on that page.

General Instructions

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on Lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Products Coordinating Committee
SE:W:CAR:MP:T:M:S
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

Exhibit B2

Form **4506-T**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution. *If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2010, filed in 2011, will not be available from the IRS until 2012. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

_____ _____ _____ _____

Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return . . . . . ☐

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

		Phone number of taxpayer on line 1a or 2a
Sign Here ▶ **Signature** (see instructions)	Date	
▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)		
▶ **Spouse's signature**	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

What's New

The IRS has created a page on IRS.gov for information about Form 4506-T at *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

CAUTION. *Do not sign this form unless all applicable lines have been completed.*

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note. If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P. O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Products Coordinating Committee
SE:W:CAR:MP:T:M:S
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Exhibit C

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name _____ *Date of Birth _____ *Social Security Number _____

I authorize the Social Security Administration to release information or records about me to:

*NAME _____ *ADDRESS _____

_____ _____

_____ _____

*I want this information released because: _____
There may be a charge for releasing information.

_____

_____

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- ☐ Social Security Number
- ☐ Current monthly Social Security benefit amount
- ☐ Current monthly Supplemental Security Income payment amount
- ☐ My benefit/payment amounts from _____ to _____
- ☐ My Medicare entitlement from _____ to _____
- ☐ Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- ☐ Complete medical records from my claims folder(s)
- ☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) _____

_____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Form **SSA-3288** (07-2010) EF (07-2010)